Practicing Szasz: A Psychologist Reports on Thomas Szasz's Influence on His Work

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Abstract

Thomas Szasz died on September 8, 2012. With his death, many of us, not enough, are left with deep concern about his legacy and the continuing influence of his ideas. This one man's ideas have directly or indirectly influenced my ongoing work as a psychologist. Specific areas that I will discuss below include power and language, issues of coercion, and psychiatry and the law. I will also discuss deeper and subtler influences regarding language, as well as the effect of Szasz as a model of precision and clarity, persistence, and courage. Finally, given that I am a professional counselor, and that Szasz worked for decades as a psychoanalyst, I want to discuss his ideas about counseling per se and how they have affected my own work. I hope that my experience will have a small positive effect in keeping alive and in play the profoundly important ideas of this great man.

Keywords

Thomas Szasz, psychiatry, behavioral sciences, psychology, social sciences, forensic psychology, counseling, ethics, religious studies, humanities, psychiatry and the law

Introduction

Thomas Szasz died on September 8, 2012. With his death, many of us, not enough, are left with deep concern about his legacy and the continuing influence of his ideas. Here I discuss some of the myriad ways this one man's ideas have directly or indirectly influenced my ongoing work as a psychologist. I hope that my experience will have a small positive effect in keeping alive and in play the profoundly important ideas of this great man.

Tom Szasz died at age 92. He became a medical doctor at age 24 and chose a psychiatric residency for at least two reasons. He wanted to train in psychoanalysis and he already had an agenda:

> Strange as it may sound, just as I wanted to go to medical school to learn medicine, not to practice it, I served a psychiatric residency to qualify as a psychiatrist and be eligible for training in psychoanalysis, not to practice psychiatry. I felt that I would rather earn a living as a psychoanalyst than as an internist; that I would then have more leisure and opportunity to pursue my intellectual—literary, social, political—interests, and that the role of psychoanalyst would provide a platform from which *I could perhaps launch an attack on what I had long felt were the immoral practices of civil commitment and the insanity defense* [emphasis added]. (Schaler, 2004, p. 18)

Szasz became a psychiatrist with the thought of launching an attack on psychiatry that would end or at least significantly reduce the use of civil commitment and the insanity defense. He stayed true to this goal until he died.

I have been involved in the so-called mental health field for about 40 years now. My first job after graduating from college with a bachelor's degree in psychology in 1975 was in a residential treatment center for children, and in 3 years I learned about the systematic drugging of children even then, at least in the institutions with which I became familiar. Like Szasz in his choice of a residency in psychiatry, I went on to choose graduate school in psychology because I wanted to work with people, and with awareness that "mental health" professionals were ethically challenged. I knew there were problems with the profession I was entering, but was not nearly as clear as Szasz in my understanding of the profession.

I barely knew Szasz at the time. I had heard of *The Myth of Mental Illness*, and when I finally read that classic, I understood the main point, but got bogged down in his game theory analysis of human behavior and lost interest. As a child of the 1960s, I gravitated to the work of the British psychiatrist R. D. Laing—a man who Szasz abhorred (Szasz, 2008a)—and read many of his books. Laing's writing was helpful in offering a radical criticism of standard psychiatric ideology and practice, especially as a fresh buffer and counterweight to the mainstream teachings of the university and graduate school I attended. So by the time I became a psychologist in 1983, I knew enough to be concerned about my

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profession. I think I had the idea, however, that I could be a counselor, reject the medical model of "mental illness," and somehow be separate from the dehumanization that Laing wrote about.

Very early on as a counselor, that fantasy died. As client after client came in already hurt by prior experiences at the hands of my fellow "mental health professionals," the profound question of how to be ethical in a largely unethical profession gained a harsh immediacy. It became clear that the only way to remain in my profession would be to focus my activist energies, formerly mostly in the realm of peace and justice issues related to militarism, as a dissident psychologist. It seemed to me that even my progressive allies, who seemed clear about so many forms of social and economic injustice, had a huge blind spot when it came to psychiatric oppression, so I thought I might be a bridge between the general progressive movement and the folks that I referred to as the mental health liberation movement. In any event, like Szasz when he chose a psychiatric residency, I now had an agenda. By reading psychiatrist Peter Breggin's (1991) *Toxic Psychiatry*, I learned more about the harmfulness of psychiatry's biological treatments.

My study of Szasz has allowed me to gain some of his clear vision, and cut through the mystification and obfuscation that passes as psychiatric today. His influence comes primarily from his writing but also indirectly through the influence on me of specific students of his work.

The core of Szasz's work is about liberty and responsibility. Specific areas that I will discuss below include power and language, issues of coercion, and psychiatry and the law. I will also discuss deeper and subtler influences regarding language, as well as the effect of Szasz as a model of precision and clarity, persistence and courage. Finally, given that I am a professional counselor, and that Szasz worked for decades as a psychoanalyst, I want to discuss his ideas about counseling per se, and how they have affected my own work.

The Myth of Mental Illness

Tom Szasz was the clearest thinker and writer that I have known; his influence has been to help me see and think more clearly, especially in regard to my work. It began with *The Myth of Mental Illness* (Szasz, 1961); despite the ongoing massive denial of the undeniable—that the concept of mental illness is a metaphor, and that psychiatry failed 52 years ago, and still fails, to meet the Virchowian standard of disease as a confirmable physical or chemical abnormality in regard to the myriad "mental illnesses" extant today—I have remained able to see the distinction between a metaphor and an objective disease. My ongoing study of Szasz has been vital to withstand the relentless, mind-numbing propaganda in my field. Neurologist Fred Baughman, Jr., a dedicated leader in the struggle to keep this distinction, and its ramifications, clear, has also been a great help and support to me on this. Shortly after Szasz's death, I called Baughman. After we both lamented his passing, Baughman shared with me his frustration about the fact that some of his best allies seemed to be devoting a lot of time and energy to "alternative treatments," mostly nutritional, of things like so-called attention deficit/hyperactivity disorder (ADHD), which Fred has always called a total fraud (Baughman, 2006). It also brings to mind what Szasz (1976) said in his book, *Schizophrenia: The Sacred Symbol of Psychiatry*, after pointing out chemist Linus Pauling's (1901-1994) claim that schizophrenia was curable by "megavitamin therapy": "We assume that Pauling accepts his psychiatric colleagues' dictum that what they *call* schizophrenia *is* schizophrenia—a posture that ill becomes a scientist of his stature" (p. 109). Baughman's lament validates the need to do all we can to prevent Szasz's ideas from disappearing in Orwell's "memory hole."

Here is a summary from *Lexicon of Lunacy* on the relevant distinction:

> In short, no psychiatric diagnosis is, or can be, pathology-driven; instead, all such diagnoses are driven by nonmedical (economic, personal, legal, political, and social) factors or incentives. Accordingly, psychiatric diagnoses do not point to pathoanatomic or pathophysiological lesions and do not identify causative agents—but rather refer to human behaviors. Moreover, the psychiatric terms used to refer to such behaviors allude to the plight of the denominated patient, hint at the dilemmas with which patient and psychiatrist alike try to cope as well as exploit, and mirror the beliefs and values of the society that both inhabit. (Szasz, 1993b, p. 9)

Seeing and understanding that the concept of mental illness is a metaphor, and that psychiatric diagnoses are based strictly on behavior, is vital to clear thinking. Nevertheless, it often makes little difference to individuals who are hurting, anxious, or depressed, and want medical or financial help or social support—likewise, probably even more so, to those who want someone else to get "help." They generally do not know that a series of writers, most recently Gary Greenberg (2013), have thoroughly exposed the politics and invalidity of the diagnostic manual (*Diagnostic and Statistical Manual of Mental Disorders* [*DSM*]) of the American Psychiatric Association. Similarly, they frequently do not really care about the scientific validity of the chemical imbalance or bad gene that qualifies them, or the troubling or troubled one they want to get "help" for. However, I have found the information is deeply appreciated and very helpful to many who have been misled by the ubiquitous propaganda of the industry and the frequent pronouncements of the helping professionals about the biological and/or genetic defects that constitute mental illness. While the industry, represented by groups such as the National Alliance on Mental Illness (NAMI), has campaigns about overcoming the stigma on mental illness—meaning encourage people to accept their disease without shame—I have been honored to support many recovering psychiatric patients who are grateful and empowered to know they really are *not* carrying an organic

defect that is a permanent mental illness, hence meaning permanent treatment, and some degree of disability (Whitaker, 2010). They consistently find liberation from stigma by rejection of the lie of mental illness, not by acceptance of their "disease." In a similar vein, I have had the good fortune of supporting a great many parents, and others, who are immensely relieved and empowered to discover that their children, or other loved ones, are not in fact defective and doomed to a failed and miserable life.

> The point is not that psychiatric diagnoses are meaningless, but that they may be, and often are, swung as semantic blackjacks: cracking the subject's respectability and dignity destroys him just as effectively, and often more so, as cracking his skull. The difference is that the man who wields a blackjack is recognized by everyone as a public menace, but one who wields a psychiatric diagnosis is not. (Szasz, 1966, p. 206)

The Myth of Mental Health

This is the tip of the iceberg in regard to the work of Thomas Szasz. It is also the tip of the spear of the psychiatric industry. Normal necessitates abnormal; if mental illness is a myth, then mutatis mutandis—as Szasz was wont to say—mental health must also be. The imperative for mental health professionals is seemingly to restore to health, but actually, given the biopsychiatric belief in the incurability of mental disease, to control the "progression of the illness." The operative word is, of course, control, and the method is the action of "treatment." It is most interesting and illuminating to read Szasz's *Schizophrenia* and learn about the roots of biopsychiatry. In the first chapter, titled "Psychiatry: The Model of the Syphilitic Mind," he points out that at the turn of the 20th century almost a third of asylum inmates were syphilitic. German psychiatrist Emil Kraepelin (1856-1926) invented "demential praecox" in 1898 and Swiss psychiatrist Eugen Bleuler (1857-1939) invented "schizophrenia" in 1911, renaming and expanding the concept. In 1904, German psychiatrist Alois Alzheimer (1864-1915) published the first paper describing the histopathological indicators characteristic of syphilis, and by 1909, German physician Paul Ehrlich (1854-1915) had developed Salvarsan for the treatment of syphilis. Szasz lays out the case that this scientific advance validated and locked in the mind-set that continues in psychiatry today—that mental illness is biologically based disease and that aggressive treatment is necessary for restoration of mental health (even though mental illness is considered incurable!)—and remains impervious to consideration of scientific fact. In any event, the concepts of mental illness and mental health are Siamese twins, inseparable without radical surgery—called "psychiatric treatment"—which will be dangerous, and is often life threatening (Elias, 2007).

In my opinion, one of Szasz's most valuable teachings is that psychiatric diagnoses do not describe anything of real use to individuals or those who want to offer real support. These words from his book, *Schizophrenia*, explain:

> The entire literature on "schizophrenia"—now extending backward in time for nearly seventy [now 100] years, and encompassing hundreds of thousands of "learned" books and essays in all the important languages—is, in my opinion, fatally flawed by a single logical error: namely, all of the contributions to it treat "schizophrenia" if it were the shorthand *description* of a *disease*, when in fact it is the shorthand *prescription* of a disposition; in other words, they use the term *schizophrenia* as if it were a *proposition asserting* something about psychotics, when in fact it is a *justification legitimizing* something that *psychiatrists* do to them. (Szasz, 1976, p. 88)

The point is profound. The core of Szasz's work is about freedom and responsibility—and it is about challenging medicalized oppression (Breeding, 2011). A fundamental piece of oppression theory is that all oppressions entail a claim to virtue that justifies the mistreatment of a specific group of people, simply because they are in that group.

On Language

Thomas Szasz was a master of language, and of rhetoric; to read his work is to learn and to grow in mental power and wisdom. His prime focus was on psychiatry, but always through the lens of philosophy and ethics for individuals and society. The following short quote provides one powerful guide for me:

> Although linguistic clarification is valuable for individuals who want to think clearly, it is not useful for people whose social institutions rest on the unexamined, literal use of language. (Szasz, 1993b, p. 1)

I have humbly discovered, however, that it is one thing to agree with an aphorism, and another to live it. Clarifying language is exceedingly hard work, especially when you are taking on a language into which you have been thoroughly conditioned, and which is put forth in ongoing waves by your profession, the media, and now the public at large. I first heard this pithy little statement by humorist Josh Billings (1818-1885) from Szasz, and I remember it because it makes the point so well: "The problem's not that people don't know anything, but that they know so many things that ain't so." And everyone knows about the pains and tragedies of mental illness, and the need for treatment, and that schizophrenia is genetic, and that depression is caused by a chemical imbalance, and that people in psychiatric hospitals are there for their own good, and so forth.

In my own self-examination, I have discovered layer upon layer of unexamined language, and my habitual patterns of using words that imply things I don't really believe. I now do better using plain speech instead of psychological jargon, I say "diagnosed as" but don't use diagnoses, and I often recognize questions with underlying assumptions that violate my own beliefs—like "Does my child have ADHD?" Szasz affected me by his writings, but his greatest influence on me

here was indirect, through another close friend and admirer of his, Leonard Roy Frank, a survivor of psychiatric abuse as a young man, and now a leader for decades in the fight for liberation from psychiatric oppression. Frank is known in some literary circles as editor of the *Random House Webster's Quotationary* (Frank, 1998); relevant to readers of this article, he edited *The History of Shock Treatment* in 1978 and *The Electroshock Quotationary* in 2006. Most especially relevant, Frank worked intensively with Szasz in 2010 and 2011, editing *The Szasz Quotationary* (Frank, 2011); this is an extraordinary collection, published in October 2011. Frank came by his mastery of language through hard work. For one, he spent years of study recovering from 50 insulin coma shocks and 35 electroshocks, systematically creating loose leaf notebooks, and later computer files, of words that he was relearning. Then over the years, he studied Szasz and others, and systematically worked to translate psychiatric jargon into plain speech. I sought Frank out around 1994, when I became active in challenging electroshock, and he became, among other things, my main mentor in examining and simplifying my way of addressing issues in psychology and psychiatry. I learned to speak and write in more or less plain speech, and I still turn to Leonard for plain speech checks today.

Psychiatry as an Agent of Social Control

Psychiatric rhetoric would have us believe that countless people—virtually everyone at some time or other—suffer from mental illness, and that treatment of mental illness is an important, beneficent branch of medicine. Szasz says it's all about power. One of his truly classic works, first published in 1970, is titled, *The Manufacture of Madness: A Comparative Study of the Inquisition and the Mental Health Movement* (Szasz, 1997). This book, perhaps more than any other, helped me understand mental health system oppression. Szasz lays out a fascinating history of the Inquisition, arguing that as we humans shifted from a primarily religious zeitgeist to a scientific worldview, so did the powers that be shift from using religious claims to virtue for their oppressive actions to scientific (medical) claims. Because I was raised Catholic, his analysis was especially meaningful to me. The relevant analogy, derived from the book, is as follows:

> The inquisition is to heresy as psychiatry is to mental illness.

During the Inquisition, the working manual was the *Malleus Maleficarum* (The Hammer of Witches), which affirmed that belief in witches was an essential part of the Catholic faith and, of course, that it was the duty of the inquisitors to act forcefully to save the soul of anyone suspected of being a witch, or otherwise deemed a heretic. As an example of the inquisitors' methods, test by "swimming" was popular in 17th-century England. The accused witch was restrained and thrown into the water. If she floated, she was guilty; if she sank, she was innocent. That the latter usually resulted in drowning was not a problem because her soul, the inquisitors claimed, went to heaven. Szasz argues that the results of modern diagnostics closely resemble the swimming ordeal. While some witches may have survived dunking, I agree with him that it is the exceedingly rare "madman" who survives psychological testing. My own experience has taught me, for example, that it is the rare child selected out for testing of so-called attention deficit disorder (ADD) who is not labeled as "mentally ill," and then receives the toxic, dangerous, and life-shortening "treatments." Research clearly validates that there is a presumption of "mental illness" by mental health officials and that it is rare for judges to not go along with a psychiatrist's opinion that an individual needs "treatment" (Scheff, 1984).

The inquisitors presumed guilt; psychiatry presumes mental illness. Just as the claim to virtue for the coercive force of the inquisitors was to save souls, so psychiatrists claim to save minds for the "patient's" own good. That countless Americans are incarcerated in psychiatric institutions every year is testament to the fervor with which psychiatrists impose their so-called "treatments." What makes inquisitors and psychiatrists so dangerous is that in both cases the government authenticates, justifies, and in many instances rewards (through insurance payments, for example) their actions. These discretionary powers are granted largely due to the fact that Inquisitors and psychiatrists, each in their time, were seen not as punishing persecutors but as their victims' benefactors. Szasz points out that the pious inquisitor would have been outraged at the suggestion that he was the heretic's foe, not his potential savior. In our time, one surefire way to elicit a psychiatrist's rage is to suggest he is the adversary of his involuntary patient. Whether it is the small heresy of a child failing to fulfill the expectations of school or family, a young person failing to meet the family's expectations of emerging adult independence, or of those we call political dissidents who fail to toe the patriotic line, branding that individual as mentally ill is the way to assert control and restrict his or her freedom.

This is a damning analogy; if one takes it to heart, it is necessary to make a profound choice. Do you stand on the side of the inquisitors or with the right of heretics to freedom of thought and expression, and the right to be left alone? Do you use "mental illness" as a justification to treat a person as less than a free moral agent, and curtail his or her rights to liberty and self-determination? Or do you stand for freedom of belief and action? In all relationships involving people who for whatever reason are perceived as being different, this choice is ever-present, most certainly in everything I do as a psychologist.

I want to make clear a very important point here related to the intersection of two of Szasz's key ideas. First, the myth of mental illness points out that "mental illness" is a metaphor, and that the model of biological psychiatry is a

theory—psychiatric diagnoses are based on behavior; none is made by confirming a specific physical or chemical abnormality. Second, as just stated, the heart of Szasz's work is to point out and challenge psychiatric coercion. As the guiding model of psychiatry today is biological, it follows that coercion occurs within this framework and that large numbers of citizens are forcibly drugged. It does not follow, however, that biological intervention is to be equated with coercion. It is absolutely true that many people choose to use psychiatric drugs. In today's direct to consumer advertising market, many in fact seek out a doctor specifically to ask for a drug. Szasz was a true libertarian who insisted on the right of people to use whatever drugs they wanted; he abhorred coercion. He even declined participating in the effort of some of us to ban electroshock, arguing that if a person wants to have their brain damaged, that is their right.

The most dramatic deprivation of liberty is total removal of a citizen from society by incarceration in a state-run, sanctioned, or financed facility. Regarding such action, the bottom line for Szasz lies in this one sentence from 1963: "A person should be deprived of liberty only if proved guilty of breaking the law" (p. 240). A large part of his work was devoted to examination of psychiatry and the law.

Privacy and Coercion

Most counselors avoid overtly dealing with psychiatry and the law, restricting themselves to office appointments; they try to avoid "severe" cases. In reality, even if a counselor insists on refusing anyone who smacks of a potential problem, it is virtually impossible to avoid situations where a client gets into something edgy—a custody problem, a child getting into trouble at school, a client becoming extreme, and especially the problem of suicide, which I will address separately. Given current ethical policies and the current legal practices in society concerning psychiatry, counselors will inevitably face the ethical choices that Szasz laid out.

One simple yet important example lies in the question of privacy. Privacy concerns are central in psychology and psychiatry, and no less so for Szasz. He believed and practiced an absolute standard of privacy in the contract between himself and his clients. In the modern world of "mental health services," privacy has been severely, often totally, compromised. It is routine practice to report to insurance companies, to child protective services (CPS), to courts and lawyers, to government agencies, to family members, to just about anyone. One common denominator has to do with who is paying the "provider." Szasz was aghast at such arrangements, and I would urge anyone who is uncertain or has not thought deeply about this slippery slope to spend some time with his writings. A bottom line here is that when a "mental health professional" acts as an agent of the state in legal proceedings "in the best interests of"—really against—an individual defendant ("patient"), privacy is not even in the game.

Psychiatry and Children

It is actually quite common for counselors to deal with the law. One example is when there is any kind of actual or potential involvement of state protective services for children in situations where there is any suspicion of abuse or neglect. Given that judgments in these instances are quite subjective, especially in cases of neglect, which constitute the majority of child protective service cases, this comes up frequently for those who work with children and families. The straight up ethics policy is a demand to report in any suspected case; once one takes a close look at the limits and problems with actual child protective service agency practices, however, it is not so simple (Baughman & Breeding, 2003).

One situation I frequently encounter involves parents reaching out or taking action in response to their "problem child." My entry into private counseling in the 1980s just happened to coincide with the pharmaceutical industry's discovery of children as a largely untapped market for psychiatric drugs, the invention of ADD in 1980 and ADHD in 1987 by the American Psychiatric Association, and the subsequent discovery and diagnosis of millions of school-age children needing treatment with stimulant drugs (Breeding, 2007). My need to respond to this phenomenon was a catalyst for political activism, and it has been my pleasure to disrupt this action on many an occasion and to offer a decent alternative to many adults in parenting their challenging children. One specific decision as a counselor is whether you will work with families who choose to give psychiatric drugs to their children. I don't, unless it is to support them in thinking and deciding on actions to wean their children and go down a different road.

A most significant place that the law comes in regarding psychiatric labeling and drugging of children is the educational system through the Individuals with Disabilities Education Act (IDEA), which in 1991 added ADHD as a qualifying disability for special education monies and services. Coercion comes into play here as many parents are pressured to diagnose and drug their children, and many struggle with a felt need to get a diagnosis to qualify a child for special education resources and accommodations. I have often consulted with parents in this situation, and I consider it my moral duty to engage in serious conversation. This selection of children is a very slippery slope, an example of the "therapeutic state" that Szasz challenges (Szasz, 1984), one that has resulted in huge numbers of people on welfare for psychiatric disability in the United States (Whitaker, 2010).

I became very involved in lobbying for two laws that were passed in Texas in 2003; one made it illegal for teachers and other school personnel to suggest a diagnosis or recommend a drug for a child; the other made it illegal for CPS to accuse a parent of medical neglect for refusing to administer a psychotropic drug to his or her child (Breeding, 2003a). Related

to the involvement of CPS, I have worked with a number of divorced parents who wanted help with challenging a coparent, often in a regrettably hostile situation, who was already administering psychiatric drugs to their child, or wanting to. I do not often choose to get involved in custody battles, but in these cases, I will do what I can to support the parent who wants to protect his or her child from the drugs.

While Szasz did not write a lot about children and families, here is an excerpt from a short speech he gave a few years back that summarizes his position:

> Labeling a child is stigmatization, not diagnosis. Giving a child a psychiatric drugs is poisoning, not treatment. I have long maintained that the child psychiatrist is one of the most dangerous enemies not only of children, but of adults, of all of us who care to the most precious and most vulnerable things in life. And those two things are children and liberty. (Szasz, 2008b)

Psychiatry's Twin Pillars of Power: Involuntary Commitment and the Insanity Defense

Another common experience I have had is when a parent has the urge to, or actually does call in the state—the police, usually, sometimes mental health deputies—on an older child who is "acting out," or judged as being in distress. In the former, it is often possible to help avoid such an action with a little encouragement, information, and support. The latter very often involves supporting the parent to process regret and disillusionment at the results of thinking that the state can do a better job for their family than they can. There is often a rude awakening to the fact that, once the state is involved, choice is gone or at least greatly limited, and one is at the mercy of the psychiatrists in charge. I have also seen this in situations where an adult voluntarily enters a psychiatric facility, only to experience the truth that once inside, you can leave only when a psychiatrist says you can, not when you want to. There can be no truly voluntary psychiatry as long as involuntary commitment remains an option for the family or psychiatrist. I also often counsel adults who want to work on recovering from the effects of trauma suffered at the hands of the mental health system, and I do provide nonmedical support for some who have decided to wean themselves off psychiatric drugs. Much of the latter involves working through fear, shame, hopelessness, and the false belief that they will necessarily deteriorate if they discontinue taking these drugs; these are residual effects of psychiatric labeling and treatment (Breeding, 1998).

Nevertheless, I think most psychologists think of themselves as not being involved with psychiatry and the law, and consider that the domain of the forensic psychology specialty, where "experts" do evaluations and testify on issues of insanity and competency. Szasz wrote extensively on these dynamics (1965b, 1970, 1987) as they speak to the heart of his abhorrence at the egregious violations of liberty perpetrated by this system. I have been involved in many cases of technically legal psychiatric coercion. Oftentimes, it has been as simple as testifying at a state hospital commitment hearing. If you attend a few of these hearings, and think about what you are observing, two things quickly become obvious. First, the rituals of court, with judge, prosecutor, and defense attorney, sure do look like criminal proceedings. Szasz's quip that to verify disease, regular doctors use pathologists, but psychiatrists use lawyers is tragically apt.

Psychiatrists do not use pathologists to verify mental illness because they can't. As Szasz (1987) wisely put it,

> Psychiatrists insist that schizophrenia and manic-depressive psychosis are brain diseases. Textbooks of pathology describe and discuss all known bodily diseases, including brain diseases. Accordingly, one way to verify whether schizophrenia and manic-depressive psychosis are brain diseases is to see what the authors of textbooks of pathology say about them. Well, the fact is that they do not say anything about these alleged diseases: they do not mention them, as they simply do not recognize mental illnesses as bodily diseases. (p. 71)

Second, you would notice the fact that the deal is rigged; it is rare for the psychiatrist's opinion not to win out. I have been involved with several cases where my showing up and testifying, especially after consulting with the defense attorney and encouraging a real defense (as opposed to the general practice of mostly collaborating with the prosecutor "for the patient's own good"), actually resulted in a judge's decision to release the defendant.

If one works with people accused of being seriously mentally ill—as I sometimes do—things often get thorny, as issues of competency and "dangerousness to self and others" come into play. It is impossible to determine the number of Americans who are forcibly incarcerated in psychiatric institutions every year, but they are surprisingly large. Based on extrapolation from a California sampling in the latter 1980s, a conservative estimate is 1.5 million, a testament to the fervor of such "treatment" (Citizens Commission on Human Rights International, 1994). The flip side of such widespread "involuntary commitment" is the insanity defense. The following from Szasz (1982) summarizes the dynamics of psychiatry's twin pillars of power:

> Why do we talk about the rights of mental patients? Who threatens or abridges them? The answer is painfully obvious: relatives, physicians, psychiatrists, judges, legislators—all those responsible for the complex web of images, justifications, and policies that result in institutional psychiatry and its involuntary patients. Commitment, involuntary mental hospitalization, is, of course, the paradigm of psychiatric power. In my opinion, it is also a paradigm of the perversion of power: for if the "patient" is not a criminal, then he or she has a right to liberty; and if the patient is a criminal, then he or she ought to be restrained and punished by the criminal law, like anyone else . . .

> Involuntary mental hospitalization and the insanity defense should be seen for what they are: symmetrical symbols of psychiatric power. In the one case, the psychiatrist "accuses" the innocent; in the other, he "excuses" the guilty. Civil commitment and the insanity defense both create and confirm the impression of psychiatric expertise, where none exists. Civil commitment and the insanity defense also foster the impression that they provide a socially beneficial solution for troubling problems of human existence, when, actually both aggravate these problems. In short, both are inimical to, and indeed incompatible with, the principles of a free society (*The Szasz Quotationary*, p. 10)

I think a family member initiates the most common path to psychiatric incarceration, but anyone can call in the police and/or mental health deputies, express a concern, report a disturbance, and start the process. The fact that it is, in some ways in some places, a bit more difficult to get someone committed today than in times past—and a little easier to challenge someone's commitment if help is mobilized—is owing to a significant degree to the ongoing, relentless ruckus Szasz has made in arguing for liberty and due process rights for citizens, even those accused of being mentally ill. Nevertheless, the commitment mill runs full-time, and it goes mostly unchecked. It is a way to deal with troubled or troubling conduct that falls short of criminality, and it is generally a two-step process involving incarceration and drugging. Although court proceedings for these two events are officially separate, they tend to be handled concurrently, or in rapid succession; as psychiatry today means biopsychiatry, mental illness means psychiatric drugs as treatment. Both incarceration and drugging are assaultive actions, but each is called medical treatment—hence, the apt title of Szasz's book on the history of psychiatry, *Coercion as Cure* (Szasz, 2007).

A psychologist who "practices Szasz" is likely to also wear the hat of a legal advocate, at least on occasion, and although I do not have space here to tell the stories, this is certainly true for me. For the interested reader, here are references to three cases that have been at least partially documented (Breeding, 2006, 2012; Gottstein, 2001).

On Thomas Szasz and Compassion

Before delving into "practicing Szasz" as a counselor per se, I want to comment on criticism of Szasz by his colleagues. Such criticism is vast (Schaler, 2004), and reflects the degree of threat that psychiatrists believe his ideas pose to their profession. Although there are many specific criticisms, I will only respond to one here—that Szasz lacks compassion for the "mentally ill."

As a practicing psychologist who mostly agrees with Szasz, I face many of the same criticisms. When I am on the front lines at the legislature challenging mental health screening and "suicide prevention" because I see it mostly as a marketing tool for Big Pharma, and as a dangerous threat to our young people, I am in direct opposition to most of my profession, which accepts the rhetoric that such screening is an effort to find and meet the needs of mentally ill children. I am accused of being uncompassionate. The same goes with challenging psychiatry and the law, as in a case where a judge chastised me for considering that a psychiatric incarceration could be just as bad, or worse, than going to jail.

Szasz's great sin was his conviction that rights of liberty should apply to all, not just those who escaped the judgment of psychiatry that they were mentally ill. The title of his book, *Cruel Compassion* (Szasz, 1994), aptly summarizes his conviction that coercion is cruel, no matter the rhetoric. At the same time, in his summation of *The Myth of Psychotherapy* (Szasz, 1978) he referred to psychotherapy as "the secular cure of souls" (p. 208). He worked as a private counselor throughout his academic tenure in Syracuse. Szasz was tough, but he was also kind. I agree with him that state coercion is a cruel assault on liberty, and to call it otherwise is an Orwellian justification of oppression. Regarding opinions on Szasz, I defer to my friend Leonard Frank who knew Szasz well, and last week when remembering him, simply said how good-hearted a man he was. The following quote is just one glimpse into the caring heart of Szasz:

> If the Other's affliction lies in his soul rather than his body, then our urge to help him cannot be satisfied without our feeling empathy for him, without our establishing a bond of intimacy with him. (Szasz, 1993a, p. xiv)

Privacy and Autonomy

I mentioned above the absolute value of privacy in Szasz's life and ideas, most especially in regard to counseling. In researching this book, I read Szasz's (1965a) book, *The Ethics of Psychoanalysis: The Theory and Method of Autonomous Psychotherapy*, in which he used the term autonomous psychotherapy, and laid out the principles of such an approach. Szasz wrote that, "autonomy is the only positive freedom whose realization does not injure others" (p. 22), further asserting the requirement of a voluntary, private contract for such a relationship. I was fascinated to discover that Szasz viewed psychoanalysis as a big step forward in support of individual freedom. He argued that "Freud devised a method of psychotherapy to extend the patient's autonomy and named it 'psychoanalysis'," (p. viii) even while he railed against that same name applying to procedures that at the time of his writing, and obviously still today, curtail autonomy. I have been "practicing Szasz" for many years, but reading *The Ethics of Psychoanalysis* has already helped me to stress the importance of clients' taking responsibility for their actions as a way to enhance their autonomy. Based on my reading of Szasz, I know my own approach to counseling is different from his in some ways, as of course it must be. As an example, although a review of his writing on psychoanalysis affirms that Szasz saw the value of catharsis, in general he did not write much about emotion. In contrast,

I often do emphasize emotional discharge in my work; I also often focus on trauma and sometimes do transpersonal work.

In an interview with *Reason* editor Jacob Sullum, Szasz had this to say in a response to a query about his approach to therapy:

> To me the whole idea of calling it "therapy" is crippling. So there was a kind of understanding between the other person and me that we were having a conversation about what he could do with his life. That obviously involves adopting different tenets of sorts—different ways of relating to his wife, his children, his job. The premise was that the only person who could change the person was the person himself. My role was as a catalyst. You are making suggestions and exploring alternatives—helping the person change himself. The idea that the person remains entirely in charge of himself is a fundamental premise. (Sullum, 2000)

I, too, dislike the term *therapy* and for similar reasons, so I use the word *counseling* instead. In any event, one fundamental point that can hardly be overstated in considering counseling is the ongoing, pervasive impact of the structure of the modern "mental health system," in particular the hierarchy of a medical model that positions psychiatrists as the alpha dogs. In *The Myth of Psychotherapy* (Szasz, 1978), Chapter 5 begins with this sentence: "The psychotherapist's identity rests on that of the psychiatrist" (p. 67). Of course, the psychiatrist's identity rests on the presumed existence of mental illnesses as medical entities, which he is said to treat.

On Power

In the 2000 interview quoted above, Sullum asked whether psychiatrists have more or less power than they used to have. Szasz's response should give pause to thoughtful counselors, "mental health professionals":

> I think they have much, much more power, but it has become increasingly covert and subtle. If you focus on psychiatrists per se, then perhaps they have a little less power, but the power has been diffused among "mental health professionals": school psychologists, grief counselors, drug treatment specialists, and so on. It pervades society. Sixty years ago, when I went to medical school, this kind of activity was limited entirely to psychiatrists.
>
> So traditional psychiatrists may have less power. They certainly don't have the feudal slave estates of the old state hospitals, where the patients were washing their cars. That's gone. On the other hand, there is a Tocquevillean kind of oppression—a softer kind of totalitarianism.

Iatrogenic Trauma

There are a great many ways in which counselors are affected by the structure of our mental health system, but much of it can be described this way. In counselor training, one learns about theories of behavior and distress, and theories of counseling. The nuts and bolts of counseling tend to be about personal anguish and trauma, and relationships and such—the effects of how we have been hurt. What most powerfully shook me up when I started professional counseling about 30 years ago was the presence of a whole other level of hurt; I was witnessing in my clients a parade of people who had been hurt by the very people they had reached out to, or been sent to, for help—that is, my fellow mental health professionals. Sometimes, it was the stuff that is agreed on as unethical by the vast majority, and certainly by the official ethics committees of the professional associations—things like sexual relationships between a counselor and client. More often, though, it was the effect of "customary and usual practice," such as the ubiquitous use of psychotropic drugs, and the less frequent but all too common electroshock. There was, of course, the bane of Szasz's lifework, coercion and its destructive effects. It is amazing how many people can and do think they are still functioning as counselors, as opposed to jailers, when they work with people who have been forced to see them. Most pervasive are two things that many people do not even see, and that reading Szasz is a magnificent aid in gaining the eyes to see. These are the debilitating effects on everyone involved—client, counselor, friends, and family—of believing in the myth of mental illness and the inherent defects entailed, and the undermining of autonomy and responsibility. I am absolutely aligned with Szasz in this aspect of his views on counseling:

> The goal is to assume more responsibility and therefore gain more liberty and more control over one's own life. The issues or questions for the patient become to what extent is he willing to recognize his evasions of responsibility, often expressed as "symptoms." (Wyatt, 2000)

Talking and Listening

To me, this short quote is consistent with my reading of Szasz, in which I see a consistent deliberate eschewal of power and control as a counselor, and a genuine humility. I like Barry Duncan and Scott Miller's research on counseling effectiveness. In their book, *The Heroic Client* (Duncan & Miller, 2000), they show that the single biggest factor in determining counseling outcomes is "extratherapeutic." There are a great many models of counseling, but Duncan and Miller's work means that results have less to do with the counseling per se than with what the client does outside of counseling. I think Szasz knew this, and that even if it were not true, he still would have insisted that such an attitude was the only respectful, and truly helpful way to go. He said it like this:

> The result of psychotherapy can only be that the subject is, or is not, persuaded to feel, think, or act differently than has been his habit. The client changes some of his ways or he remains the

> same. The psychotherapist does not do anything but listen and talk. If there is any change in the client, it is, in the last analysis, brought about by the client himself. (Szasz, 1978, p. 190)

I want now to share one more piece that is relevant to the ironic cruelty discussed above that goes with acceptance of biopsychiatry's failure to meet the basic standards of scientific medicine in terms of objective standards of proof for its assertions. My experience is that maturity involves an ongoing, humbling process of disillusionment, a huge part of which involves repeated realizations that the teachings and beliefs of various personal and societal authorities are not worthy of the naive trust that I had given them; of course, Szasz's lifework has been to disillusion us of trust in the beliefs and practices of psychiatry. In *The Myth of Psychotherapy*, Szasz provided interesting history about Sigmund Freud and Carl Jung. He highly values their work and, at the same time, examines it in the light of these themes of autonomy and coercion. It is of note that he concluded his chapter on Jung with the assertion that Jung, despite his groundbreaking work on the secular cure of souls, exhibits the same failings as Freud in that "when the going gets difficult, Jung too falls back on regarding the mental patient as medically sick and the physician-psychotherapist as a medical healer" (Szasz, 1978, p. 176).

As previously suggested, the identity of the counselor rests in a hierarchy of dependency on the psychiatrist. In my own work, I also discovered that this is perhaps most clearly seen when the going gets a bit tough. When counseling is not "working," when problems persist, especially those deemed severe as in "severe mental illness," counselors tend to defer to psychiatrists. We are already severely compromised when we refer to our clients as "patients." Such a designation obviously implies a medical model and a sick individual; worse, it reflects an attitude, a predisposition to respond in a medical way. Specifically, counselors readily and regularly refer their "patients" to psychiatrists for "medication," especially whenever the going gets a bit tough. This practice reflects a conscious, or at the very least an implicit deference and dependence on psychiatry, an acceptance of biopsychiatric theory and practice, especially when the going gets a bit tough, and a sad hopelessness and lack of confidence in both human nature and psychological theory and practice about the nature of distress and recovery. It reflects the deep conditioning of "mental health professionals," and the resultant demoralization best elucidated by psychologist Bruce Levine (2007). Worse still, such a conditioning also leads to our collaboration in the ongoing coercion and violations of liberty in the name of "therapy." Counselors refer people to psychiatrists and feel like they have done the right thing; like Pontius Pilate, their hands are now clean.

It seems to me that to sacrifice the reassuring notion that psychiatric coercion is help, or even further that a referral for drugs or electroshock is real help, may be handled in two ways. One of these is to harden the heart, to in fact become less compassionate. The other is to let the heart be broken, to directly face the deep grief and humility that comes with seeing another suffer and being unable to substantially help. Szasz often said that life is difficult and that tragedy is not uncommon; he faced it head on, and did his best to empower others in the only way he saw, which was to assume responsibility.

In a fairly recent interview, Szasz was asked what advice he might give to a potential counseling client. His response is a good segue to our next subject:

> My advice for a prospective client is to investigate his prospective therapist, to not trust him unless he proves himself trustworthy, and to be clear in his own mind about what he expects the therapist to do for him. Becoming a psychotherapy client is like becoming married: it may be a trap which it is much harder to escape from than to avoid. In short, beware of therapists, especially if you have reason to suspect that they will lock you up if they think you may kill yourself. (Howes, 2009)

Suicide

Like all counselors, I was taught the ethic that coercion in the cause of treating mental illness was a benevolent necessity, especially so with suicide. All counselor codes of ethics make clear that the ethical thing to do is to force treatment on anyone deemed to be actually suicidal, or even potentially suicidal if there is any doubt. As suicide is the main trigger for psychiatric coercion, and the primary justification for the shift from a voluntary counseling mode to a coercive treatment mode that inevitably means deprivation of liberty and forced administration of drugs, this is a pivotal point for any serious consideration of practicing Szasz. And it is a point that he took head on. In *Fatal Freedom* (Szasz, 1999), he deeply explores the subject. While psychiatry declares that suicide is a symptom of mental illness, Szasz insisted on defending human agency and wrote that it must be seen as a choice by a human agent; to do otherwise results in the annihilation of liberty and dignity. It is my view that anyone who avoids wrestling with the intellectual and moral terrain of the ethics of suicide cannot possibly be able to see, think, and act clearly and consciously as a counselor. I will simply leave you with the title of Szasz's second book on the subject to summarize his judgment on the current practices in this area: *Suicide Prohibition: The Shame of Medicine* (Szasz, 2011).

The practical implications of Szasz's position on suicide are simple:

> Those who want to prevent a particular person from committing suicide must content themselves with their power, such as it might be, to persuade him to change his mind. (Szasz, 1992)

An obvious consequence of a counselor embracing mainstream ethics about suicide is that from a Szaszian perspective, whenever a suicidal dynamic comes forward, the

counselor, no matter the outer title or appellation, immediately, and in my view tragically, shifts from counselor ally mode to potential jailer and adversary. Perhaps less obvious, but equally true, is that the counselor also once again forsakes his or her own beliefs and practices about counseling. As the going got tough, the counselor bailed out. There is of course no guarantee, but my own belief and experience is that to work through and recover from deep despair, emotional pain, and hopelessness about life, at least two things are often necessary, and both are forsaken when coercion comes into play. The paradox of change is that in order for something to change or transform at a deep level, it must first be faced and accepted for what it is. The paradox is that for suicidal despair to lessen it must be accepted and embraced. Psychiatry's refusal to accept such feelings, and to suppress them mightily, makes it difficult if not impossible to heal. A second related condition for lessening despair and restoring hope is the acceptance and listening to the despair and anguish by another person who is trusted. Conditions that encourage hiding or denying such feelings to avoid rejection or coercion are harmful and counterproductive; in my view it is absolutely necessary to reveal and share suicidal despair to get through it.

Conclusion: A Way of Being Ethical

Practicing Szasz is a way to be more ethical in a profession that is unethical in many ways. I use the term psychiatric oppression to refer to the ways that the mental health profession systematically mistreats those who are labeled mentally ill and acts as an agency of social control for mainstream society. I want to end this article by considering four primary mechanisms by which psychiatry enforces or holds other oppressions in place (Breeding, 2003b). The first mechanism is suppression of thought and feeling. This is obvious in the use of psychoactive drugs and electroshock and, in overt coercion, less so with subtle threats and labeling and paternalistic attitudes and practices. The work of Szasz is an ongoing denunciation of suppression of thought and behavior by psychiatry. In terms of counseling, Szasz emphasized relationships and, of course, autonomy and responsibility. While he clearly valued free expression, I think I place more emphasis on emotional release. Most important, Szasz wanted to empower individuals and hated anything that put unnecessary constraints on personal freedom.

A second function of psychiatric oppression is distraction from social injustice by blaming the victim. I am not a pure libertarian like Tom Szasz, but I am very clear that psychiatry blames and scapegoats individuals. In so doing, its primary function is political, and Szasz is by far the best source on dissecting and understanding the politics of psychiatric social control. His work is consistently about challenging oppression; the title of his book, *Liberation by Oppression* (Szasz, 2002), which compares slavery and psychiatry, is a good example of his direct assault on psychiatry's Orwellian function in our society. One major reason it is hard for people, and especially those who serve as agents of oppression, to delve deeply into Szasz's work is because he kills the sacred cow and forces one to see the slaughter for what it is. Jacob Sullum also asked Szasz whether he saw any encouraging developments since he started talking about psychiatric oppression. The answer reveals Szasz as a compassionate champion of the oppressed:

> The encouraging development is essentially the uprising of the slaves, the increasing protestation by ex-mental patients, many of whom call themselves victims. Through all kinds of groups, they have a voice now which they didn't have before. We should hear from the slaves. Psychiatry has always been described from the point of view of the psychiatrist; now the oppressed, the victim, the patient also has a voice. This I think is a very positive development. (Sullum, 2000)

My third point is that psychiatry enforces adherence to society's rules, however immoral and unethical they might be. Szasz (1961) laid out his game theory in his most famous book, *The Myth of Mental Illness*, and he looked at the rules, at the games of life and of its institutions again and again. He believed in the value of politeness and etiquette, and of the necessity of the law to enforce order in the face of overt criminality, but his overarching value was liberty. Social psychology, most famously through the works of Stanley Milgram (1975) on obedience and Philip Zimbardo (2008) on the power of the situation and social roles, has made clear that a relationship structure involving real or perceived differences in power is a setup for coercion. Subtle or not, these forces specifically pull us toward conformity and obedience to prescribed rules and behavior. Any counselor one who does not see this clearly will tend to consciously or unconsciously use his or her rank to control a client. A conscious decision for autonomy, and a vigilant guard against the situational pulls toward coercion are necessary to avoid becoming an adversary of that client. A key part of Szasz's solution was the contract between client and counselor, agreed to before the relationship begins. Knowing his work has definitely helped me in this regard.

Finally, psychiatry is oppressive by providing false hope and absolution, thus impeding or denying possible genuine movement toward greater freedom and autonomy. The hope one feels at getting help, at finding an explanation for the problem is tragically perverted when the explanation is that one is defective, and when the hope for a better life involves the use of drugs, much less electroshock, that may provide temporarily relief or suppression or stimulation, but lead to addiction, dependency, and various long-term illnesses. Likewise, the absolution may feel good—to believe that you are not to blame, your family is not to blame, society is not to blame, it is just regrettable that you suffer from "a chemical imbalance," "a lithium deficiency," "a brain defect" or some other unsubstantiated biological problem, but it is not your fault, and we can help you cope. This is a tragically false

absolution, and as usual, Szasz is best at striking at the heart of this lie. This false absolution utterly undermines the great values of freedom and liberty. Dependency on the identity of being a sick patient and dependency on the judgment of medical experts or any other kind of experts about one's life, together with dependency on drugs, destroys the movement toward greater autonomy and higher levels of personal responsibility. Thomas Szasz is not having any of this nonsense and, with his help, neither am I.

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References

Baughman, F. (2006). *The ADHD fraud*. Victoria, British Columbia, Canada: Trafford.

Baughman, F., & Breeding, J. (2003). *On psychiatry and child protective services in the United States*. Retrieved from http://www.wildestcolts.com/parenting/d-cps.html

Breeding, J. (1998). *Drug withdrawal and emotional recovery* (The Rights Tenet, Winter 1998, National Association for Rights Protection and Advocacy). Retrieved from www.wildestcolts.com/psych_opp/b-psychiatric_drugs/5-drug_wd.html

Breeding, J. (2003a). *Legislators strike a blow for parent rights: Two new laws put a halt to coercion of parents to put Texas children on psychotropic drugs* [Press release]. Retrieved from http://www.wildestcolts.com/safe_ed/j-press_rel060403.html

Breeding, J. (2003b). *The necessity of madness and unproductivity: Psychiatric oppression or human transformation*. London, England: Chipmunka.

Breeding, J. (2006). The case of Sohrab Hassan: Assault on liberty in the Texas mental health courts. *Journal of Humanistic Psychology*, *46*, 243-254.

Breeding, J. (2007). *The wildest colts make the best horses* (3rd ed.). London, England: Chipmunka.

Breeding, J. (2011). Thomas Szasz: Philosopher of liberty. *Journal of Humanistic Psychology*, *51*, 112-128.

Breeding, J. (2012). *A psychiatric assault on liberty: The case of Carolyn Barnes*. Retrieved from www.madinamerica.com/2012/12/a-psychiatric-assault-on-liberty-the-case-of-carolyn-bar-nes-2/

Breggin, P. (1991). *Toxic psychiatry*. New York, NY: St. Martin's Press

Citizens Commission on Human Rights International. (1994). *Involuntary commitment*. Retrieved from http://www.cchrstl.org/documents/involuntary_commitment.pdf

Duncan, B. L., & Miller, S. D. (2000). *The heroic client: Doing client-directed, outcome-informed therapy*. San Francisco, CA: Jossey-Bass.

Elias, M. (2007, May 3). Mentally ill die 25 years earlier. *USA TODAY*. Retrieved from http://usatoday30.usatoday.com/news/health/2007-05-03-mental-illness_N.htm

Frank, L. R. (1978). *The history of shock treatment*. San Francisco, CA: Author.

Frank, L. R. (1998). *Random House Webster's quotationary*. New York, NY: Random House.

Frank, L. R. (2006). *The electroshock quotationary*. Retrieved from http://www.endofshock.com/102C_ECT.PDF

Frank, L. R. (2011). *The Szasz quotationary: The wit and wisdom of Thomas Szasz* (Kindle ed.). Available at www.amazon.com

Gottstein, J. (2001). *Legal memorandum on the case of Rodney Yoder*. Retrieved from http://gottsteinlaw.com/yoder/memo.pdf

Greenberg, G. (2013). *The book of woe: The DSM and the unmaking of psychiatry*. New York, NY: Blue Rider Press.

Howes, R. (2009). Seven questions for Thomas Szasz. In K. Hoeller (Ed.), *Therapy: A user's guide to psychotherapy* (Psychology Today blog). Retrieved from http://www.psychologytoday.com/blog/in-therapy/200901/seven-questions-thomas-szasz

Levine, B. (2007). *Surviving America's depression epidemic: How to find morale, energy, and community in a world gone crazy*. White River Junction, VT: Chelsea Green Publishing.

Milgram, S. (1975). *Obedience to authority*. New York, NY: Harper & Row.

Schaler, J. A. (Ed.). (2004). *Szasz under fire: The psychiatric abolitionist faces his critics*. Chicago, IL: Open Court.

Scheff, T. (1984). *Being mentally ill: A sociological theory*. Chicago, IL: Aldine.

Sullum, J. (2000, July). Curing the therapeutic state: Thoms Szasz interviewed by Jacob Sullum. *Reason*. Retrieved from http://reason.com/archives/2000/07/01/curing-the-therapeutic-state-t

Szasz, T. (1961). *The myth of mental illness: Foundations of a theory of personal conduct*. New York, NY: Hoeber-Harper.

Szasz, T. (1963). Summary and conclusions. In *Law, liberty, and psychiatry: An inquiry into the social uses of mental health practices* (pp. 237-253). Syracuse, NY: Syracuse University Press.

Szasz, T. (1965a). *The ethics of psychoanalysis: The theory and method of autonomous psychotherapy*. New York, NY: Basic Books.

Szasz, T. (1965b). *Psychiatric justice*. New York, NY: Macmillan.

Szasz, T. (1966). Psychiatric classification as a strategy of personal constraint. In T. Szasz (Ed.), *Ideology and insanity: Essays on the psychiatric dehumanization of man* (pp. 190-217). Syracuse, NY: Syracuse University Press.

Szasz, T. (1970). *Ideology and insanity: Essays on the psychiatric dehumanization of man*. Garden City, NY: Doubleday Anchor.

Szasz, T. (1976). *Schizophrenia: The sacred symbol of psychiatry*. New York, NY: Basic Books.

Szasz, T. (1978). *The myth of psychotherapy: Mental healing as religion, rhetoric and repression*. Garden City, NY: Anchor Press.

Szasz, T. (1982, October). On the legitimacy of psychiatric power. *Metamedicine*, *3*(3), 315-324.

Szasz, T. (1984). *The therapeutic state: Psychiatry in the mirror of current events*. Buffalo, NY: Prometheus Books.

Szasz, T. (1987). *Insanity: The idea and its consequences*. New York, NY: John Wiley.

Szasz, T. (1992). The fatal temptation: Drug control and suicide. In T. Szasz (Ed.), *The medicalization of everyday life: Selected essays* (pp. 90-93). Syracuse, NY: Syracuse University Press.

Szasz, T. (1993a). *"Foreword" to Seth Farber, madness, heresy, and the rumor of angels: The revolt against the mental health system*. Chicago, IL: Open Court.

Szasz, T. (1993b). *A lexicon of lunacy: Metaphoric malady, moral responsibility, and psychiatry*. New Brunswick, NJ: Transaction.

Szasz, T. (1994). *Cruel compassion: Psychiatric control of society's unwanted*. New York, NY: John Wiley.

Szasz, T. (1997). *The manufacture of madness: A comparative study of the inquisition and the mental health Movement*. Syracuse, NY: Syracuse University Press.

Szasz, T. (1999). *Fatal freedom: The ethics and politics of suicide*. Syracuse, NY: Syracuse University Press.

Szasz, T. (2002). *Liberation by oppression: A comparative study of slavery and psychiatry*. New Brunswick, NJ: Transaction.

Szasz, T. (2007). *Coercion as cure: A critical history of psychiatry*. New Brunswick, NJ: Transaction.

Szasz, T. (2008a). Debunking antipsychiatry: Laing, law, and largactil. *Existential Analysis*, *19*, 316-343.

Szasz, T. (2008b). *Speech at citizens commission on human rights event*. Retrieved from https://www.youtube.com/watch?v=zQegsqYhuZE

Szasz, T. (2011). *Suicide prohibition: The shame of medicine*. Syracuse, NY: Syracuse University Press.

Whitaker, R. (2010). *Anatomy of an epidemic: Magic bullets, psychiatric drugs, and the astonishing rise of mental illness in America*. New York, NY: Crown Publishers.

Wyatt, R. (2000). *An interview with Thomas Szasz, MD: Liberty & the practice of psychotherapy*. Retrieved from http://www.psychotherapy.net/interview/Thomas_Szasz

Zimbardo, P. (2008). *The Lucifer effect: Understanding how good people turn evil*. New York, NY: Random House.

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